FLORIDA DEPARTMENT OF HEALTH

Dental Health History

Name:
ID No:
Birthdate:

In the following questions, answer **YES** or **NO**, whichever applies. Your answers will be considered confidential.

1. Do you (PATIENT) have or have you (PATIENT) had any of the following:

Rheumatic Fever or Heart Murmur		Neurological Problems	___
Heart Trouble or Shortness of Breath	___	Tuberculosis (TB) or Persistent Cough	
High Blood Pressure		Diabetes or Excessive Thirst	
Fainting or Dizzy Spells	___	Epilepsy or Seizures	
Stroke	___	Kidney Problems or Excessive Urination	___
Anemia or Blood Problems		Liver Problems or Hepatitis	
Sickle Cell Anemia	___	Venereal Disease	___
Excessive Bleeding or Bruise Easily	___	AIDS/HIV Positive	___
Blood Transfusions	___	Cancer	___
Allergies or Skin Rash		Pregnancy	___
Asthma		Trimester	___
Thyroid Problems	___	Painful or Swollen Joints	
Emotional Problems	___	Other:	___

2. Are you (PATIENT) currently under care of a physician (doctor)? No
   If yes, list the name of the doctor.

3. Have you (PATIENT) been hospitalized in the last 2 years? No
   If yes, why?

4. Are you (PATIENT) currently taking any medication, pills or drugs? No
   If yes, list.

5. Are you (PATIENT) allergic to or ever experienced any ill affects from local anesthetic (Novocain), penicillin, or any drugs/pills? Ie. Rash, itching or fainting. No
   If yes, describe

6. Have you (PATIENT) ever experienced any unfavorable reaction from previous dental treatment? No
   If yes, describe.

7. Are you (PATIENT) currently having any dental pain or problems? No
   If yes, describe.

I certify that I have read and understand the above questions and have answered the questions to the best of my knowledge. I have asked for an explanation of any terms (words) that I did not know (if any), and my questions have been answered to my satisfaction. I will not hold my dentist, or any of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

I also understand that before treatment is provided, I have the right to have the benefits, alternatives, and significant risk factors associated with this treatment explained to my satisfaction.

Signature of Patient_____Date_____
(If patient is a child, parent or legal guardian must sign) Relationship _____

Comments by Dentist: _____
_____
_____

Signature of Dentist _____ Date_____

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